

Alabama Medicaid HIV Counseling

HIV PRE-TEST COUNSELING

Counselor's
initials _____

1. Document that patient was provided pre-test counseling. In order for patients to give informed consent for HIV testing, pre-test counseling must include:
 - An explanation regarding the nature of HIV infection and HIV-related illness;
 - An explanation of the modes of HIV transmission and HIV prevention measures;
 - An explanation of the HIV test, including a description of the procedure to be followed and the meaning of the test results;
 - An explanation of the benefits of taking the test, including the benefits of early diagnosis and medical intervention;
 - An explanation that the test is voluntary;
 - An explanation of confidential testing;
 - Information regarding the psychological and emotional consequences of receiving test result;

Counselor's
initials _____

2. Include signed Informed Consent (ADPH-CL-109/Rev. 6-94)

Counselor's
initials _____

3. If patient declined testing, document reason.

ADDITIONAL REQUIREMENTS - FOR PRE-TEST COUNSELING

Counselor's
initials _____

- Record justification for additional pre-test counseling and/or testing if needed.

Signature of Counselor _____, Title _____ Date _____

HIV POST-TEST COUNSELING

Counselor's
initials _____

1. Document HIV test result: _____

Counselor's
initials _____

2. Document that patient was provided post-test counseling. Post-test counseling must include:
 - An explanation of the test result;
 - Assistance in coping emotionally with the test result;
 - An explanation of the modes of HIV transmission and HIV transmission prevention measures;
 - An explanation regarding the need to notify contacts to prevent transmission of HIV infection; information regarding partner notification options.
 - Information regarding the importance of early medical evaluation and treatment;
 - Referral for medical and support services, including emotional support, and referrals for partner notificationservices. Referrals should be made to the extent that they are deemed necessary for the patient.

Counselor's
initials _____

3. Document referrals to medical and other services, if needed.

ADDITIONAL REQUIREMENTS - FOR POST-TEST COUNSELING

Counselor's
initials _____

- Record justification for additional post-test counseling if needed.

Signature of Counselor _____, Title _____ Date _____